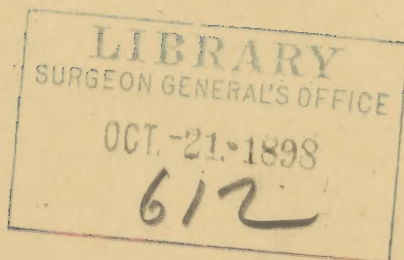
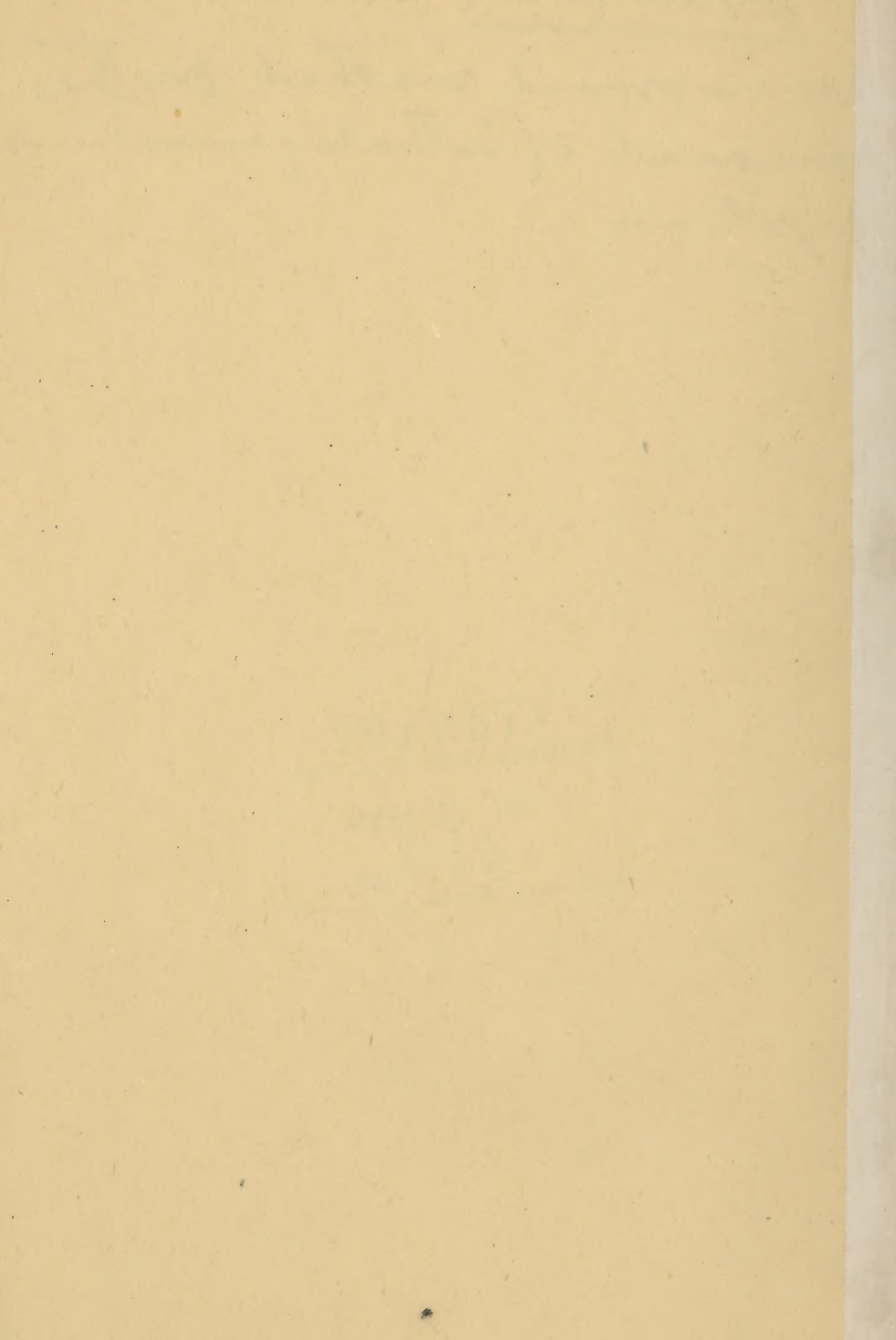


Hawkins (Hos. H.)

an improved method for the  
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Hawkins (T.H.)

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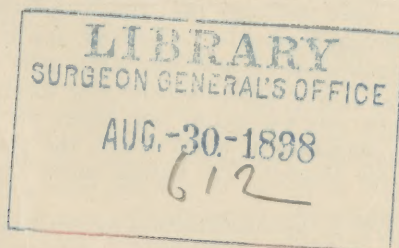
BY THOMAS H. HAWKINS, A.M., M.D.,

Professor of Gynecology and Abdominal Surgery, Gross Medical College.

DENVER, COLO.

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## AN IMPROVED METHOD FOR THE REMOVAL OF INTRALIGAMENTOUS CYST.

An intraligamentary cyst has been more or less of a bugbear to many abdominal surgeons.

The different methods resorted to in the removal and management of these cysts have not given very satisfactory results; at least the writer has been for a long time discouraged, not only in the matter of mortality, which has been high, but with the after complications.

For some time past, Dr. C. K. Fleming, who is associated with me on the staff of St. Anthony's Hospital, and myself have been interested in devising some new or improved method for the management of these intraligamentous neoplasms. The method which we now use and have, we think, perfected in technique, came to us, possibly, by accident. On June 10th, 1897, a little dwarf of a woman came into St. Anthony's Hospital and was placed under Dr. Fleming's care. Examination revealed a cystic growth. On June 11th, Dr. Fleming, assisted by me, performed section. The cyst proved to be intraligamentary. While the doctor was endeavoring in the usual way to enucleate the cyst, his finger went through the wall, also tearing the capsule. The fluid escaped and the tumor collapsed. The adhesions were quite firm and the woman was not in a good condition to stand a severe surgical operation, particularly if attended with much loss of blood. While the doctor hesitated for a moment, doubtless debating in his mind the best procedure, I suggested to him to tie the ovarian artery in the usual way that one begins the first step in an abdominal hysterectomy, and then to tie the uterine artery on the same side, make his flap and amputate the uterus as by the ordinary method of hysterectomy. The doctor quickly acted upon this suggestion. In a few minutes he had the cyst practically shelled out of its capsule. We neglected, however, to tie the ovarian artery on the side of the cyst. This gave rise to some little hemorrhage, but the artery was quickly ligated and the operation completed. I asked the doctor then what he proposed doing with the capsule. He said he thought he would trim that off, cut it down and stitch the edges over the stump and up the side very much after the manner of an ordinary hysterectomy. This he did and we were both surprised at the small amount of blood lost, at the ease and facility with which the operation was done, and at the excellent condition in which it left the parts; free from oozing, no denuded surface exposed. The patient made a rapid and an uninterrupted recovery.

On the 17th of the same month a patient sent from Leadville entered St. Anthony's Hospital and came into my service. She had a large growth, filling the pelvic cavity, but much larger on the right side, which proved to be upon opening the abdomen, an intraligamentous cyst. The patient was anemic and emaciated, and certainly not in a condition to withstand a severe surgical operation. As soon as I discovered the real condition, Dr. Fleming assisting me, I first ligatured the right ovarian artery, the growth being on this side.



I then passed a ligature through the broad ligament beyond the ovary, tied and cut the broad ligament, made my flap, turning the bladder and peritoneum back in the usual way, and amputated the uterus with a strong pair of scissors, while Dr. Fleming seized the spurting uterine arteries; I then partially separated the uterus from the cyst and rapidly proceeded to enucleate the growth from below upward. The ease and simplicity of this operation impressed both of us and we wondered why we had not thought of it before, or that if any one else had resorted to the method why they had not called it to the attention of the profession. There was almost no hemorrhage; the right ureter came into view, but was pushed aside unharmed. The capsule was trimmed down until just sufficient was left to form a snug lining to the pelvis when brought together by a continuous catgut suture. The cervical canal was dilated, burnt out with the Paquelin cautery, and a small piece of gauze pushed into the canal and allowed to project into the vagina for drainage. The growth and contents weighed, together with the uterus, between twelve and fifteen pounds. The patient had had several children, the labors had always been easy, she had never experienced any special trouble in any of her confinements, yet she said when in two weeks she was ready to leave the hospital, that the operation had caused her less inconvenience than her confinements.

During the month of July it was my good fortune to operate upon a third case, with a similar growth, though not so large. The same method was pursued and the patient did well, and made an excellent recovery.

This improved method is not perhaps a new operation. Possibly others are removing intraligamentary cysts by a similar procedure. I claim nothing, except that the method of procedure was new to Dr. Fleming and myself, and I simply desire in presenting these three cases, to call the attention of the abdominal surgeons to what to us is an improved method of treating an intraligamentary cyst. I believe that this modification will greatly reduce the mortality following the removal of these growths. To summarize the advantages: First, there is very little hemorrhage; second, the operation is simplified; third, the patient makes a quick recovery; fourth, there are no bad sequelae; fifth, the mortality is reduced; and lastly, it is a perfect operation.

I remember when three or four years ago, I was in New York City, attending some lectures in one of the post-graduate schools, two patients presented themselves at the dispensary, who had had intraligamentous cysts removed. Both of them had fistulae in the abdominal walls, and were being treated by injections and otherwise in order to get rid of this complication. The surgeon informed me that he had stitched the capsule or sac into the lower end of the incision and that he would in time by cleansing the pocket heal it up by a process of granulation. The patients, if I remember correctly, had been under treatment many months. During the time of this same visit I saw a prominent surgeon in one of the eastern cities work and struggle for two hours with an intraligamentous cyst. He finally, in sheer desperation, cut it off; he cut the stump rather short. He had difficulty in making it fit anywhere, and greater difficulty in controlling the hemorrhage, and the patient, when I left the room, was well nigh exsanguinated. How he finally got out of the scrape I never learned. Since operating by the method which I have somewhat clumsily described, I can see how easily and simply this perplexed surgeon might have disposed of the exasperating tumor. I trust that those who have intraligamentary cysts to deal with, and meet with difficulty in their removal, will resort to the method accidentally hit upon by Dr. Fleming and myself.





